

INFECTIOUS DISEASE PHARMACOKINETICS LABORATORY

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Patient Last, First Name, M.I. (Required)			<input type="checkbox"/> Male <input type="checkbox"/> Female		Mail results to: (Required)
Date of Birth:	Patient ID:	Diagnosis (ICD-9) Code:			
Referring Physician:	Physician NPI #	Physician Phone #			
Fax: (<input type="checkbox"/> Fax Results)		Facility Phone #			
COMPLETE SECTION BELOW ONLY IF BILLING INFORMATION DIFFERS FROM "MAIL RESULTS TO" INFORMATION					
Please Bill: <input type="checkbox"/> Medicare <input type="checkbox"/> FL Medicaid <input type="checkbox"/> Patient (Pre-Pay) <input type="checkbox"/> Check <input type="checkbox"/> Credit Card (CC) <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Other		Name of Responsible Party (Last, First, M.I.):		Medicare (HIC) #	
Name on CC: _____ Credit Card# _____ Exp. Date _____ CVV# _____		Street Address:		Medicaid ID #	
		City State Zip		Social Security #	
		Telephone #		Patient Bills must be prepaid or accompany specimen	

(Please submit a separate requisition for each sample collection time) **Most assays require 4-7 days to complete.**

Specimen source (circle one): serum cerebrospinal fluid other: _____

REQUIRED	Drug 1	Drug 2	Drug 3	Drug 4
Drug name to be Assayed				
ICD-9 Code				
Drug Dose (mg) (Specify: PO, IV, IM)				
# Doses per week				
Date of last dose				
Time of last dose (For IV: Start/End)				
Date blood drawn				
Time blood drawn				

The number of hours after the dose to collect "peak" concentrations is shown in parentheses after each drug name below. To test for delayed drug absorption, a second sample may be collected 4 hours after the "peak". Trough concentrations (prior to next dose) are recommended for the anti-HIV and anti-fungal drugs.

Drugs(s) to be assayed (*provide 2 ml serum per test*)

AMPL	Amprenavir (2-3 H & trough)	EFVL	Efavirenz (5 H-trough)	LOPV	Lopinavir (4-6 H & trough)	RIFH	Rifampin (2 H)
ATAZ	Atazanavir (2 H & trough)	EMBH	Ethambutol (2-3 H)	MXFL	Moxifloxacin (2 H)	RFPTN	Rifapentine (5 H)
AZL	Azithromycin (2-3 H)	ETAH	Ethionamide (2 H)	NLFL	Nelfinavir (2-3 H & trough)	RTVL	Ritonavir (2-3 H & trough)
CMH	Capreomycin (2 H)	ETRA	Etravirine	NEV	Nevirapine (2 H & trough)	SAQL	Saquinavir (2-3 H & trough)
CIPH	Ciprofloxacin (2 H)	FLUCZ	Fluconazole (2 H)	OFLHL	Ofloxacin (2 H)	SMH	Streptomycin (2 H)
CLART	Clarithromycin (2-3 H)	INDL	Indinavir (1-2 H & trough)	PASH	p-Aminosalicylic acid (6 H)	TIPV	Tipranavir (3 H)
CFH	Clofazimine (2-3 H)	INH	Isoniazid (1-2 H)	POSA	Posaconazole (3-6 H)	VORL	Voriconazole (2H & trough)
CSH	Cycloserine (2-3 H)	ITRL	Itraconazole (3-4 H)	PZAH	Pyrazinamide (2 H)		
DARU	Darunavir (2-4 H)	LFLHL	Levofloxacin (2 H)	RALT	Raltegravir		
DELV	Delavirdine (2 H & trough)	LNZL	Linezolid (2 H & trough)	RBN	Rifabutin (3 H)		

Sample preparation and shipment: Collect in a plain red top, 8-10 ml tube. Separate serum from cells immediately by centrifugation and aliquot into a labeled polypropylene or similar plastic tube. Use a separate tube for each test ordered. Allow room for expansion of sample inside tube. Freeze at -70°C if possible (otherwise -20°C.) Ship on ≥ 3 lbs. dry ice via overnight. **SHIP SAMPLES TO BE RECEIVED MONDAY THROUGH FRIDAY. DO NOT SHIP ON FRIDAY OR SATURDAY.**

List other medications patient is currently taking: _____

For UFL Use Only

Date Received: _____

Time Received: _____

Condition: (circle one)

Frozen

Partially Frozen

Thawed

